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Office of Administrative Law Judges
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Issue Date: 21 November 2005

CASE NO. 1999-BLA-00807

In the Matter of:

ELLIOTT ROWE, JR.
Claimant
v.

JOHNSON COAL COMPANY,
Employer:

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

DECISION AND ORDER ON REMAND

Employer appealed the Decision and Order on Remand (99-BLA-0807) of Administrative Law Judge Richard K. Malamphy dated May 20, 2003 denying Employer's motion for modification and awarding benefits on a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. '901 *et seq*. (the Act). This case was before the Benefits Review Board for the fifth time.

The miner filed an application for benefits on April 11, 1989 (DX 1) and the matter was initially referred to this Office on March 20, 1990 (DX 24). In January 1992, Administrative Law Judge Daniel Stewart remanded the case for review of new medical evidence (DX 25). The case was subsequently assigned to another administrative law judge and a hearing was held in June 1993 (DX 35). In a decision and order issued on August 12, 1993, Administrative Law Judge Richard K. Malamphy concluded that while coal workers' pneumoconiosis had been established by x-ray evidence, the miner had not established he was totally disabled by coal workers' pneumoconiosis under any of the criteria in 20 CFR 718.204 and, accordingly, benefits were denied (DX 37).

The Claimant appealed the 1993 decision, and in a footnote in the November 1994 decision the Board stated that: "The administrative law judge's findings that claimant established the existence of pneumoconiosis pursuant to Section 718.202 and that claimant failed to establish total disability pursuant to Section 718.204(c)(l) and (3) are affirmed as unchallenged on appeal. *Skrack v. Island Creek Coal Co.,* 6 BLR 1-710 (1983). (DX 49). On November 30, 1994, the Benefits Review Board remanded the case for further consideration on the issue of total dis-ability under 20 CFR 718.204(c)(2) and (4) (DX 49).

In a Decision and Order On Remand, issued on March 30, 1995, Judge Malamphy again denied the claim for benefits (DX 51) finding total disability due to pneumoconiosis was not established. Claimant appealed a second time to the Board. In an order of remand in September 1996, the Board directed the administrative law judge to reconsider 20 CFR 718.204 (b) and (c)(2) and (4). In particular, the Board directed Administrative Law Judge Malamphy to consider Dr. Sundaram's status as the miner's treating physician (DX 56). Subsequent to the remand, Claimant submitted additional reports from Dr. Sundaram. In an Order issued on March 11, 1997, Administrative Law Judge Malamphy admitted the newly submitted evidence into the record and allowed the Employer until March 28, 1997 to inform the court if any rebuttal evidence would be submitted. In a Decision and Order issued on May 2, 1997, the administrative law judge granted benefits to the claimant commencing February, 1993 (DX 65).

Employer appealed to the Board and on May 15, 1998, the Board affirmed the award of benefits. The Board found the administrative law judge did not err in admitting evidence after the hearing since he allowed the employer time to respond. In addition, the Board found the administrative law judge did not err in crediting Dr. Sundaram's opinion and he properly found it reasoned. The Board also found Dr. Sundaram's opinion was sufficient to establish pneumoconiosis was a contributing cause of Claimant's disability and the administrative law judge credited this opinion and, therefore, the Board affirmed the administrative law judge's finding that Claimant was totally disabled by pneumoconiosis (DX 75). *Rowe v. Johnson Coal Co.,* BRB No.97-1140 BLA (May 15, 1998)(unpub.).

On June 29, 1998, Employer submitted a petition for modification arguing that the administrative law judge made factual mistakes in finding Claimant totally disabled due to pneumoconiosis and requesting a new examination of Claimant (DX 76). The District Director denied Employer's request for modification on October 16, 1998 stating modification is not intended to provide the Employer a vehicle to re-adjudicate a claim through the development of new evidence (DX 95). On February 19, 1999, the District Director again denied the request for modification noting modification is not for errors or misjudgments of counsel nor is it to present an opportunity to argue a new theory. The District Director stated Employer had not presented a specific mistake of fact. The District Director concluded modification is not for questions of law decided against a party (DX 99).

The matter was referred to this Office on April 12, 1999. Judge Malamphy initially granted the request for modification in a determination issued on April 20, 2000. Judge Malamphy denied a motion to compel an examination but did allow the Employer the opportunity to submit existing medical records which are not currently part of the record. Judge Malamphy admitted two additional medical opinion reports into the record as submitted by the Employer (EX 1 and 2). Judge Malamphy also admitted additional hospital records submitted by Claimant as Claimant's Exhibits 1 through 6. Judge Malamphy stated, "As previously stated, the presence of coal worker's pneumoconiosis has been established and will not be discussed further." Judge Malamphy then found the new records established Claimant had recent pulmoary infections but they were unrelated to coal worker's pneumoconiosis. Judge Malamphy concluded the new opinions demonstrated a mistake of fact in the previous determination of total

disability due to coal worker's pneumoconiosis and, therefore, he approved the request for modification and denied benefits.

Claimant appealed. On June 20, 2001, the Board concluded Judge Malamphy failed to provide his rationale for crediting the medical opinions of Drs. Fino and Westerfield submitted by the Employer on modification. In addition, the Board stated it was not clear what the basis was for Judge Malamphy's mistake of fact finding. Therefore, the Board vacated judge Malamphy's finding that a mistake of fact was demonstrated and remanded for reconsideration of all of the evidence for any mistake in fact. In a footnote, the Board noted the ALJ should address Employer's contention that the prior finding of the existence of pneumoconiosis was a mistake of fact. The Board also stated that "Ultimately, the administrative law judge should determine whether reopening the claim renders justice under the Act." *Rowe v. Johnson Coal Co.,* BRB No. 00-0782 BLA (June 20, 2001)(unpub.)

On remand, in a Decision and Order issued on January 18, 2002, Administrative Law Judge Malamphy found the x-ray evidence sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1) finding the majority of the chest x-ray films, including the most recent films, were read positive for pneumoconiosis. Judge Malamphy also relied upon the opinion of Dr. Sundaram since he had continued to be the miner's treating physician during numerous hospitalizations from September 1997 through December, 1999 and had continuously diagnosed coal worker's pneumoconiosis and chronic obstructive pulmonary disease. Judge Malamphy concluded that Claimant had been disabled under 20 CFR § 718.204 (c)(4) since February 1993. The administrative law judge concluded there was no mistake of fact in the decision of May, 1997 and he found Claimant entitled to benefits.

Employer appealed. It is this most recent appeal by Employer that is the subject of the Board's most recent action on this matter, the second remand on the petition for modification, and the fifth time the Board has considered this case.

In a Decision and Order issued on January 24, 2003, the Board found Judge Malamphy failed to analyze all of the evidence of record as the previous remand order required and, therefore, the Board vacated the January 18, 2002 Decision and Order. The Board found Administrative Law Judge Malamphy relied primarily upon the quantity of x-ay readings and failed to address the various qualifications of the physicians who provided the readings. The Board specifically rejected Employer's allegation of error that the administrative law judge failed to weigh all of the evidence regarding pneumoconiosis since this case arises in the Sixth Circuit which has not adopted that method of establishing the existence of pneumoconiosis. Thus, the Board stated, the regulations at Section 718.202(a)(1) – (4) provide alternative methods of establishing pneumoconiosis in the Sixth Circuit. On the issue of total disability, however, the Board found Judge Malamphy failed to address all of the medical opinion evidence of record, he failed to address the pulmonary function study evidence and he failed to discuss the blood gas study evidence. The Board remanded for consideration of all of the evidence of record in determining whether it establishes a mistake in a determination of fact. The Board also instructed the ALJ on remand to evaluate the evidence regarding total disability pursuant to Section 718.204(b) and then separately consider the evidence regarding disability causation pursuant to Section 718.204(c). The Board also stated, "On remand, after further evaluation of all of the evidence of

record, the administrative law judge is instructed to reconsider whether reopening this claim will render justice under the Act." *Rowe v. Johnson Coal Co.,* BRB No. 02-0366 BLA (Jan 24, 2003)(unpub).

Claimant filed a timely motion to reconsider, requesting *en banc* reconsideration of the Board's Decision and Order. Claimant contended the Administrative Law Judge had properly exercised his discretion in finding that reopening the record would not render justice under the Act. The Board denied Claimant's motion for reconsideration in a Decision and Order on Reconsideration *En Banc* issued on September 3, 2003. The Board stated that the question of whether reopening the claim renders justice under the Act is a finding to be made only after there is a determination that a basis for modification has been established. Since the Board vacated the judge's findings regarding whether a basis for modification had been established, the Board found it properly vacated the judge's findings regarding whether reopening would render justice under the Act. That analysis should be made only after the judge determines that a basis for modification has been established. (*Rowe v. Johnson Coal Co.*, BRB No. 02-0366 BLA (September 8, 2003) (unpub).

The matter was then sent to this Office on November 17, 2003. A hearing was scheduled by Administrative Law Judge Stuart Levin for September 28, 2004. Judge Levin was unable to attend the hearing, however, so the case was reassigned to me. At the hearing, the parties submitted additional medical evidence which was admitted into the record. Because the case has been remanded twice subsequent to the Employer's petition for modification, and because Judge Malamphy admitted exhibits into the record in previous decisions and orders, clarification of the additional evidence is listed below. The parties should note that changes have been made to the exhibit identification numbers discussed at the hearing based on my review of evidence admitted into the record in the previous decisions.

Director's Exhibits 1 through 102 as labeled
Claimant's Exhibit 1 – September 1997 hospital records
Claimant's Exhibit 2 – October 1997 hospital records
Claimant's Exhibit 3 – February 1998 hospital records
Claimant's Exhibit 4 – March 1998 hospital records
Claimant's Exhibit 5 – September 1998 hospital records
Claimant's Exhibit 6 – June 1999 hospital records
Claimant's Exhibit 7 – December 1999 hospital records
Claimant's Exhibit 8 – X-ray reading of film 12/05/99 by Dr. E. Cappiello
Claimant's Exhibit 9 – X-ray reading of film 12/05/99 by Dr. T. Miller
Claimant's Exhibit 10 –Medical records and reports, Dr. I. Potter 2003 and 2004
Claimant's Exhibit 11 – medical records and reports, Dr. R. Sundaram, 2000, and 2004
Claimant's Exhibit 12 – X-ray reading of films 12/17/20, 6/14/03 and 04/19/04, by Dr. A. Ahmed
Employer's Exhibit 1 – October 1, 1999 report, Dr. B. Westerfield
Employer's Exhibit 2 – September 30, 1999 report, Dr. G. Fino
Employer's Exhibit 3 – January 6, 2000 report, Dr. B. Westerfield
Employer's Exhibit 4 – January 14, 2000 report, Dr. B. Westerfield

Employer's Exhibit 5 – February 9, 2000 report, Dr. G. Fino
Employer's Exhibit 6 – August 30, 2004 report, Dr. B. Westerfield

At the hearing, Employer renewed its motion to compel Claimant to submit to a new pulmonary evaluation. Claimant opposed this motion. Employer argues that the age of the medical evidence justifies a new pulmonary examination.

The determination of whether employer is entitled to such examination or discovery rests within the discretion of the administrative law judge. *Stiltner v. Wellmore Coal Corp*., 22 BLR 1-37, 1-40-42 (2000)(*en banc*); *Selak v. Wyoming Pocahontas Land Co*., 21 BLR 1-173, 1-177-78 (1999)(*en banc*). Employer must "demonstrate that its request to have claimant re-examined is reasonable under the circumstances." *Selak*, 21 BLR at 1-178. The issue is whether employer "has raised a credible issue pertaining to the validity of the original adjudication . . . so that an order compelling claimant to submit to examinations or tests would be in the interest of justice." *Selak*, 21 BLR at 1-179.

Employer moved earlier in these proceedings on modification to compel Claimant to attend a new pulmonary examination and was denied by the district director and by Judge Malamphy. I concur with their decisions. The record includes eleven reports by physicians who examined the miner. In addition, as noted by Judge Malamphy, Employer did not submit rebuttal evidence prior to the award of benefits when offered the opportunity. I find Employer has not demonstrated that an order compelling Claimant to submit to examinations or tests would be in the interest of justice in this case where numerous previous examinations are in the record, Employer has had the opportunity to have its medical experts review recent hospital records and Employer failed to submit any rebuttal evidence when offered the opportunity prior to the request for modification. Thus, I find no basis for allowing the Employer the opportunity on modification to compel Claimant to submit to a new pulmonary evaluation.

DISCUSSION AND ANALYSIS

The regulations provide that a determination may be modified by showing that there has been a change in conditions or a mistake in a determination of fact. 20 C.F.R. §725.310. The Board has held that in considering whether a change in conditions has been established, the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision. *See Nataloni v. Director, OWCP*, 17 BLR 1-82 (1993). In considering whether modification is established based on a mistake in a determination of fact, the administrative law judge must consider the entirety of the evidentiary record. *See Nataloni, supra*. On remand, the Board instructed me to analyze the entirety of the medical evidence to determine if any mistake in fact is established on the issue of the presence of pneumoconiosis, the issue of total disability, and the issue of total disability due to pneumoconiosis. Mistakes in fact may be demonstrated wholly by new evidence, cumulative evidence, or by further reflection the previously developed record. *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971).

Presence of Pneumoconiosis

Pursuant to Section 718.202, a living miner can demonstrate the presence of pneumoconiosis by: 1) x-rays interpreted as being positive for the disease; or 2) biopsy evidence; or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or 4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical examinations, and medical and work histories.

Chest X-ray Reports

The record includes the following x-ray reports:

EX. NO.	DOCTOR CRDNTL[1]	DATE OF X-RAY	READING
DX 25	Anderson	09-08-87	Cat. I pneumoconiosis
DX 18	Marshall, B/BCR	09-08-87	2/3 s, t
DX 25	Myers	11-30-88	1/0 q, p
DX 18	Marshall, B/BCR	11-30-88	2/3 s, t
DX 13, 25	Williams	05-08-89	0/1 q, q
DX 12	Gordonson, B/BCR	05-08-89	No pneumoconiosis
DX 83	Fino, B	05-08-89	Completely negative
DX 29	Lane, B	05-11-89	0/1 p, p
DX 25	Broudy, B	05-12-89	1/0 p, s
DX 28	Jarboe, B	05-12-89	0/1 p
DX 25	Wright	05-13-89	0/0
DX 25	Jarboe, B	06-09-89	0/1 p, p
DX 25	Potter	08-11-89	hyperinflation of chronic obstructive pulmonary disease
DX 25	Patel	11-07-89	Normal x-ray

[1] The symbol "B" denotes a physicians who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982). The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III).

EX. NO.	DOCTOR CRDNTL	DATE OF X-RAY	READING
DX 25	Baker, B	11-19-90	1/0, s, t
DX 25, 34	Baker, B	03-18-92	1/1 s, s
DX 34	Dineen, B	07-07-92	0/1 p, p
DX 27	Grimes	08-18-92	1/2 p, t
DX 27, 34	Grimes	02-11-93	pneumonia
EX 1	Caton	09-12-96	no changes since 8/95, scarring mid to lower lung fields and in the peri-hilar regions
CX 1	Reddy	09-11-97	right middle lobe pneumonia
CX 2	Reddy	10-08-97	emphysema without change
EX 1	Patel	11-26-97	chronic obstructive pulmonary disease, fibrotic changes right lower lobe are noted
CX 3	Narra	02-12-98	1) chronic obstructive pulmonary disease with interstitial fibrosis, slightly on the basis of pneumoconiosis; 2) since previous study of 10/08/97, there appears to be sub segmental atelectasis at the left base posterior; 3) suggest follow-up examination after treatment
CX 5	Reddy	09-10-98	Chronic obstructive pulmonary disease without change
CX 6	Reddy	06-11-99	Findings of significant chronic obstructive pulmonary disease
CX 7	Reddy	12-05-99	chronic obstructive pulmonary disease without change
CX 8	Cappiello, B/BCR	12-15-99	2/2 p, s, emphysema chronic obstructive pulmonary disease
CX 9	Miller, B/BCR	12-15-99	1/1 p, s, chronic obstructive pulmonary disease, emphysema
CX 10	Potter	03-25-03	1/2 p, p, emphysema
CX 12	Ahmed, B/BCR	04-19-03	1/1 p, s, emphysema
CX 12	Ahmed, B/BCR	06-14-03	1/1 p, s, emphysema
CX 12	Ahmed, B/BCR	12-17-03	1/1, p, s, emphysema

The record includes positive readings and negative readings of the chest x-ray films taken between September, 1987 and December, 2003. This includes positive and negative readings by physicians highly qualified as board certified radiologists and/or B-readers. The record also includes several x-ray readings by physicians during Claimant's numerous hospitalizations. These readings were not read for the presence or absence of pneumoconiosis and I accord little weight to these readings. I note ten of the B-reader interpretations are positive and six are negative, however, I also note four of the negative readings by B-readers noted some changes of pneumoconiosis, although only in category 0/1. The positive readings of 2003, the most recent readings of record, are uncontradicted. On consideration of all of the x-ray evidence of record, I find the positive readings by the highly qualified physicians which include readings from 1987 through 2003 outweigh the negative readings of record. I accord greater weight to the more recent positive readings but I also find the negative readings of 0/1 (all before 1992) lessen the weight I accord to the negative readings by highly qualified physicians since these x-ray films note some changes present on the x-ray films. Thus, I find on consideration of all of the x-ray evidence, Claimant has established the presence of pneumoconiosis by the weight of the x-ray evidence of record. I find, therefore, no mistake in fact in the prior finding by Judge Malamphy in his May, 1997 findings that pneumoconiosis was present as affirmed by the Board in May, 1998. I find the three newly submitted positive x-ray reports by physicians qualified as board certified radiologists and B-readers of films taken in 2003 lend support to that finding by Judge Malamphy as affirmed by the Board. Accordingly, Claimant has established the presence of pneumoconiosis by the x-ray evidence of record under the provisions of subsecion718.202(a)(1).

Biopsy Evidence and Presumptions

Claimant has not established pneumoconiosis by the provisions of subsection 718.202 (a)(2) since no biopsy evidence has been submitted into evidence. Likewise, since none of the presumptions are applicable to his claim he has not established pneumoconiosis by the provisions of subsection 718.202(a)(3).

Medical Opinion Reports

The final way to establish the existence of pneumoconiosis under Section 718.202(a) is set forth in subparagraph (a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician exercising sound medical judgment finds the miner suffers from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. The record includes the following medical opinion reports:

September 3, 1987 – Dr. W. Anderson, board certified pulmonary specialist Dr. Anderson reported pneumoconiosis, category 1 on chest x-ray and ventilatory results abnormal but above disability standards on pulmonary function study. He diagnosed category I pneumoconiosis, pulmonary function study results above disability levels and symptoms of arteriosclerotic heart disease (DX 25).

November 30, 1988 – Dr. J. Myers, board certified internist
Dr. Myers examined Claimant on November 30, 1988, reported chest x-ray findings of pneumoconiosis, 1/0 p, q, and reported results on pulmonary function study and blood gas study. Dr. Myers diagnosed chronic obstructive pulmonary disease due to smoking and coal worker's pneumoconiosis 1/0, p, q, due to coal mine dust exposure. Dr. Myers stated Claimant had a mild to moderate restrictive defect in ventilation and was not able to perform heavy manual labor (DX 25).

May 8, 1989 – Dr. C. Williams, board certified internist
Dr. Williams reported normal finding on physical examination of Claimant and reported 0/1 q, q, pneumoconiosis on chest x-ray. In addition, Dr. Williams performed pulmonary function study and blood gas study. He diagnosed chronic obstructive pulmonary disease with pneumoconiosis 0/1 p, q, due to coal mine dust exposure which had caused minimal impairment. Dr. Williams concluded Claimant had the respiratory capacity to do his usual coal mine employment (DX 10, 25).

May 9, 1989 – Dr. E. Lane, board certified pulmonary specialist
Dr. Lane reported fine to medium inspiratory rales at both bases, chest x-ray evidence of pneumoconiosis, 0/1 p, p, and pulmonary function study results which were normal. Dr. Lane also stated blood gas study values were above federal guidelines, but they did show evidence of mild hypoxemia. Dr. Lane diagnosed early pulmonary emphysema and he concluded Claimant has the respiratory capacity to do his usual coal mine employment. At a deposition taken on May 11, 1993, Dr. Lane agreed Claimant would have problems if blood gas study values fell with exercise. Dr. Lane also stated it was possible coal mine dust exposure contributed to Claimant's pulmonary emphysema but he did not think it was clinically significant. Rather, Dr. Lane stated it was his opinion the major cause of the pulmonary emphysema was Claimant's history of smoking cigarettes (DX 25, 29).

May 12, 1989 – Dr. B. Broudy, board certified pulmonary specialist
Dr. Broudy examined Claimant and reported coal worker's pneumoconiosis, 1/0 p, s, on chest x-ray. Dr. Broudy performed pulmonary function study and blood gas study. He diagnosed coal worker's pneumoconiosis but concluded Claimant retains the respiratory capacity to do his usual coal mine employment. Dr. Broudy stated at a deposition he would not expect significant or disabling pulmonary impairment with the profusion of coal worker's pneumoconiosis seen on Claimant's chest x-ray. Dr. Broudy's final diagnosis was chronic bronchitis with mild airway obstruction and chest x-ray evidence of simple coal worker's pneumoconiosis (DX 25).

May 13, 1989 – Dr. B. Wright
Dr. Wright examined Claimant, reported no evidence of pneumoconiosis on chest x-ray and normal results on pulmonary function study and blood gas study. He diagnosed no coal worker's pneumoconiosis, but did diagnose chronic smoker's bronchitis with little to no functional impairment (DX 25).

June 6, 1989 – Dr. T. Jarboe, board certified pulmonary specialist
Dr. Jarboe examined Claimant, reported chest x-ray of pneumoconiosis, 0/1, and he noted pulmonary function study of Dr. Broudy showed a mild airway obstruction. Dr. Jarboe stated since Claimant's values on the FEV-1 exceeded the federal limits, Claimant retains the respiratory capacity to do his usual coal mine employment. On May 11, 1993, Dr. Jarboe reviewed the medical records and stated the drop in arterial oxygen in February, 1993 was due to pneumonia for which Claimant was hospitalized. At a deposition in May, 1993, Dr. Jarboe stated the medical literature establishes that smoking is the most likely cause of airway obstruction. Dr. Jarboe also reviewed the medical evidence. He reiterated his written opinion that the low blood gas values in February, 1993 were a reflection of the pneumonia for which Claimant was being treated. Dr. Jarboe also stated in the absence of cigarette smoking or progressive massive fibrosis, coal mine dust exposure rarely causes disabling airway obstruction and simple coal worker's pneumoconiosis is almost never disabling (DX 31, 34).

August 11, 1989 -- Dr. I. Potter
Dr. Potter reported occasional wheeze on examination and chest x-ray evidence of chronic obstructive pulmonary disease with diffuse interstitial fibrosis. Dr. Potter also reported Claimant demonstrated a marked restrictive defect on pulmonary function study with no improvement with the use of bronchodilators. He concluded Claimant had shortness of breath on exertion, chest x-ray evidence of emphysema and interstitial fibrosis and chronic low back syndrome. Dr. Potter stated Claimant was totally disabled due to his multiple medical problems (DX 25).

March 18, 1992 – Dr. G. Baker, board certified pulmonary specialist
Dr. Baker examined Claimant and reported pneumoconiosis, 1/1 on chest x-ray. Dr. Baker reported mild restrictive ventilatory defect on pulmonary function study and mild resting hypoxemia on blood gas study. Dr. Baker diagnosed coal worker's pneumoconiosis on Claimant's chest x-ray findings and work history. He stated the etiology of Claimant's pulmonary impairment is coal worker's pneumoconiosis. Dr. Baker also stated at deposition that Claimant is not completely disabled but he would have difficulty doing hard manual labor of coal mine employment (DX 25, 34).

July 7, 1992 – Dr. J. Dineen
Dr. Dineen reported simple coal worker's pneumoconiosis was present on chest x-ray and a minimal respiratory impairment due to a minimal obstructive airway disease due to cigarette smoking. Dr. Dineen stated, "I would not expect simple coal worker's pneumoconiosis to cause any significant impairment." (DX 34). At a deposition taken on may 17, 1993, Dr. Dineen was asked if he believed simple coal worker's pneumoconiosis could be a disabling disease and he answered, "No." (DX 30). On May 20, 1993, he stated the drop in Claimant's arterial pO2 from his test on July 7, 1992 to February 11, 1993 was due to pneumonia for which Claimant was hospitalized in February, 1993 (DX 30).

Dr. R. Sundaram
The record includes a number of reports, statements and hospital reports from Dr. Sundaram. On August 17, 1992, Dr. Sundaram reported on clinical examination, chest x-ray findings and

blood gas study results. Dr. Sundaram concluded Claimant had coal worker's pneumoconiosis based on his work history and chest x-ray changes (DX 27).

In a questionnaire dated February 4, 1993, Dr. Sundaram stated he had been Claimant's treating physician since August 17, 1992 for chronic obstructive pulmonary disease and coal worker's pneumoconiosis. he stated Claimant does not have the respiratory capacity to do his usual coal mine employment based on his medical history, findings on physical examination, chest x–ray findings and breathing test results. Dr. Sundaram stated Claimant's coal worker's pneumoconiosis contributed to his impairment (DX 27).

Dr. Sundaram treated Claimant from February 11 to 18, 1993 for pneumonia and chronic obstructive pulmonary disease during a hospitalization (DX 27, 34).

At a deposition taken on May 18, 1993, Dr. Sundaram stated Claimant is not able to do exercise blood gas studies because of his shortness of breath. On review of the exercise blood gas study results obtained by Dr. Williams, Dr. Sundaram stated they showed Claimant's lungs are not able to keep up with his body's demands on exercise. Dr. Sundaram stated with the coal worker's pneumoconiosis present, Claimant is more susceptible to infections and he noted Claimant's pneumonia in February, 1993. Dr. Sundaram stated he treats Claimant's coal worker's pneumoconiosis with medications and a nebulizer. He stated Claimant is totally disabled and he stated pneumoconiosis contributes to Claimant's respiratory and pulmonary impairment (DX 27).

In a statement dated January 1, 1995, Dr. Sundaram stated he sees Claimant every four weeks for chronic obstructive pulmonary disease and coal worker's pneumoconiosis with recurrent bronchitis. Dr. Sundaram stated Claimant is totally disabled by his respiratory impairment and he has shortness of breath on limited activity. Dr. Sundaram also stated Claimant's coal worker's pneumoconiosis contributes to his pulmonary disability since he is prone to recurrent bronchitis as his resistance is lowered. The lung volume results show he is compromised by prolonged exposure to coal dust and resultant scarring of the lungs. Dr. Sundaram concluded Claimant's lungs are not functioning normally (DX 50, 61).

On September 30, 1996, Dr. Sundaram stated he was Claimant's treating physician since 1992 and he sees the Claimant every two to three months or as needed. Dr. Sundaram stated Claimant has coal worker's pneumoconiosis and chronic obstructive pulmonary disease with recurrent bronchitis. The diagnosis of coal worker's pneumoconiosis is based on work history, findings on physical examination, results of chest x-ray, and breathing test results. Dr. Sundaram again stated Claimant is totally disabled by his respiratory impairment based on findings on physical examination and breathing tests. He concluded coal worker's pneumoconiosis contributed to Claimant's respiratory impairment. Dr. Sundaram stated Claimant has shortness of breath with limited activity which is substantiated by the breathing test results and the findings on physical examination (DX 59, 61).

Various hospital records from 1997 through 2000 indicate Claimant was hospitalized from September 11 to 15, 1997 for respiratory failure, pneumonia streptococcus, and chronic obstructive pulmonary disease (black lung). A chest x-ray taken by Dr. Reddy at this time showed significant chronic obstructive pulmonary disease and right middle lung pneumonia.

Claimant was treated by Dr. Attalla but referred to Dr. Sundaram for follow-up care (CX 1). Claimant was hospitalized again from October 8 to 13, 1997 for candida infection, acute exacerbation of chronic obstructive pulmonary disease with bronchitis and coal worker's pneumoconiosis. Claimant was treated during this hospitalization by Dr. Sundaram (CX 2).

Dr. Sundaram also treated Claimant during a hospitalization in February, 1998 for purulent bronchitis, bronchopneumonia with respiratory distress with subsegemental atelectasis, chronic obstructive pulmonary disease and coal worker's pneumoconiosis (CX 3). He also treated Claimant during a hospitalization in March, 1998 for bronchopneumonia with respiratory distress, chronic obstructive pulmonary disease, and coal worker's pneumoconiosis (CX 4).

Claimant was hospitalized again in September, 1998 for bronchitis with chronic obstructive pulmonary disease and referred for follow-up treatment to Dr. Sundaram (CX 5). Claimant was next hospitalized and treated by Dr. Sundaram in June, 1999 for gram positive bacterial pneumonia, chronic obstructive pulmonary disease and coal worker's pneumoconiosis (CX 6). Claimant was hospitalized again and treated by Dr. Sundaram in December, 1999 for bacterial pneumonia with respiratory distress, chronic obstructive pulmonary disease with exacerbation and coal worker's pneumoconiosis (CX 7).

Claimant was then hospitalized in May, 2000 and treated by Dr. Sundaram for purulent bronchitis with respiratory distress, hemoptysis due to bronchitis, chronic obstructive pulmonary disease with exacerbation with acute hemoptysis and bronchitis, coal worker's pneumoconiosis and atherosclerosic heart disease (CX 11). Claimant was hospitalized again in August, 2000 and treated by Dr. Sundaram for gram positive bacterial pneumonia with respiratory distress, chronic obstructive pulmonary disease, coal worker's pneumoconiosis, and arteriosclerotic disease (CX 11).

In a statement dated July 24, 2004, Dr. Sundaram stated he had been Claimant's treating physician both in outpatient settings and while Claimant was a patient in numerous hospitalizations. Dr. Sundaram stated Claimant has coal worker's pneumoconiosis based on pulmonary function study results, blood gas study results, chest x-ray findings and physical examination findings. Dr. Sundaram reiterated his earlier opinions that coal worker's pneumoconiosis is contributing to Claimant's respiratory impairment. He stated it is difficult to separate Claimant's respiratory impairment due to cigarette smoking and his respiratory impairment due to coal mine dust exposure, however, Dr. Sundaram stated Claimant has a disabling respiratory impairment over and above what he would have sustained from his smoking history alone. On review of the hospital records and treatment records, Dr. Sundaram stated Claimant has a lung disease caused by dust exposure during coal mine employment which is a contributing factor to his breathing impairment (CX 11). On a questionnaire also dated July 24, 2004, Dr. Sundaram stated Claimant has both clinical and legal pneumoconiosis. Dr. Sundaram stated again Claimant is totally disabled and his disability is related to pneumoconiosis. Dr. Sundaram also stated Claimant currently uses oxygen at home. Dr. Sundaram concluded he was Claimant's treating physician from July, 1992 through August, 2002 (CX 11).

Dr. Ira B. Potter – July 19, 2004
In a statement dated July 19, 2004, Dr. Potter stated he is currently Claimant's treating physician. Dr. Potter noted diffuse scattered wheezes bilaterally on physical examination with an increased AP diameter and prolonged expiration. Dr. Potter reported pulse oximetry test on March 25, 2003 showed a marked desaturation. In addition, he stated pulmonary function study results of January 6, 2003 showed severe obstructive disease with no improvement with the use of bronchodilators. Dr. Potter stated Claimant has a low vital capacity which is consistent with a restrictive lung disease (CX 10). On a questionnaire dated August 9, 2004, Dr. Potter stated Claimant has clinical and legal pneumoconiosis. He stated further Claimant's coal worker's pneumoconiosis is due to coal and rock dust exposure and his chronic obstructive pulmonary disease was aggravated by coal mine dust exposure and rock dust exposure. Dr. Potter stated Claimant is totally disabled and his impairment is related to pneumoconiosis. he stated Claimant has a severe respiratory impairment secondary to coal worker's pneumoconiosis based on the marked desaturation on pulse oximetry as well as the markedly decreased peak flow rate. Based on these findings, Claimant has been on home oxygen (CX 10).

Dr. B. Westerfield – board certified pulmonary specialist
Dr. Westerfield has reviewed Claimant's medical records and written reports on several occasions. In his first report, dated August 28, 1998, Dr. Westerfield reviewed medical records and noted Claimant's x-ray readings were variable, however, his own reading was pneumoconiosis, 1/0. In addition, Dr. Westerfield stated Claimant's results on pulmonary function study were variable. He noted the hospitalization in February, 1993 which was for a serious pneumonia which he stated is not related to coal worker's pneumoconiosis. Dr. Westerfield stated it would be unfair to use the blood gas study results from this hospitalization to assess Claimant's lung condition due to coal worker's pneumoconiosis since these results reflect Claimant's pulmonary function when he was very ill with pneumonia. Dr. Westerfield concluded Claimant has coal worker's pneumoconiosis due to his coal mine employment but he has no respiratory disability due to coal worker's pneumoconiosis (DX 85).

Dr. Westerfield reviewed Dr. Sundaram's reports of January, 1995 and September, 1996 and he stated there is no objective evidence to support Dr. Sundaram's opinion Claimant's disability is due, in part, to coal worker's pneumoconiosis. Dr. Westerfield noted Dr. Sundaram is Claimant's treating physician, however, he stated there is no evidence of an impairment or respiratory disability including no results of pulmonary function study or blood gas study which show pulmonary impairment (DX 88).

Dr. Westerfield reviewed reports of Drs. Canton (September 12, 1996) and Patel (November 27, 1997) which included chest x-ray readings and CT lung scan readings. Dr. Westerfield noted neither physician diagnosed coal worker's pneumoconiosis (EX 1).

On January 6, 2000, Dr. Westerfield reviewed records of Claimant's hospitalizations in October, 1997, February, 1998, March, 1998 and June, 1999. He agreed Claimant had chronic obstructive pulmonary disease and respiratory infections with acute bronchitis and pneumonia. He stated these records did not indicate any hospitalizations or treatment for coal worker's pneumoconiosis. He stated further coal worker's pneumoconiosis did not contribute to the need for the

miner to be hospitalized (EX 3). On January 14, 2000, Dr. Westerfield stated there is no information in the records upon which to base a diagnosis of coal worker's pneumoconiosis (EX 4).

Most recently, Dr. Westerfield reviewed records from 2000 through July 18, 2004. He noted Claimant had been hospitalized again three time in 2003 for pneumonia. Dr. Westerfield stated the chest x-ray and CT lung scan reports included in the hospital records did not mention coal worker's pneumoconiosis. Dr. Westerfield did note Claimant was treated for chronic obstructive pulmonary disease and he concluded the chronic obstructive pulmonary disease was due to Claimant's cigarette smoking. Dr. Westerfield stated the medical literature shows cigarette smoking is the number one cause of chronic obstructive pulmonary disease. Dr. Westerfield stated the number respiratory infections and pneumonia are due to chronic obstructive pulmonary disease, however, he stated there is no evidence any of these respiratory symptoms are due to coal worker's pneumoconiosis. Dr. Westerfield stated there is little mention of coal worker's pneumoconiosis in the records and he stated that if coal worker's pneumoconiosis is present, it is early, simple coal worker's pneumoconiosis with no contributing symptoms to Claimant's respiratory impairment. Dr. Westerfield also stated cor pulmonale is not established since there is no evidence of right ventricle enlargement on the echocardiogram testing or on chest x-ray films (EX 6).

Dr. G. Fino – board certified pulmonary specialist
Dr. Fino also reviewed the records on numerous occasions. On August 25, 1998, he stated with the valid pulmonary function study tests, Claimant's results were normal and showed only a slight obstruction which was not clinically significant. Even if coal mine dust exposure related condition was present, the valid test results of lung function showed no impairment or inability, according to Dr. Fino. Dr. Fino concluded there is insufficient objective evidence of coal worker's pneumoconiosis, Claimant does not have an occupationally acquired pulmonary condition, there is no respiratory impairment, and, from a respiratory standpoint, Claimant can do his usual coal mine employment (DX 83).

On September 17, 1998, Dr. Fino reviewed Dr. Sundaram's reports of January 1, 1995 and September 30, 1996 as well as his deposition testimony. Dr. Fino stated he accepts the presence of pneumoconiosis even though his own x-ray reading was negative, however, there are no objective test results to demonstrate Claimant has a pulmonary disability. Dr. Fino stated the treating physician had no opportunity to make a better assessment of Claimant's pulmonary capacity since the acceptable lung studies have not shown total disability (DX 89).

On September 30, 1999, Dr. Fino reviewed the chest x-ray reports and CT lung scan reports of Drs. Caton (September 12, 1996) and Patel (November 26, 1997). He stated there is no change in his opinion that there is no coal mine dust related lung disease present (EX 2).

On February 9, 2000, Dr. Fino reviewed additional record and continued to find the negative chest x-ray readings persuasive. Dr. Fino again stated the acceptable pulmonary function study results showed no ventilatory impairment and, when Claimant was not ill, the blood gas study values were normal. Dr. Fino stated Claimant could do heavy manual labor based on his pulmonary function study results. He concluded again, there is insufficient evidence to diagnose coal

worker's pneumoconiosis, Claimant has no occupationally acquired pulmonary condition, Claimant has respiratory impairment and, from a respiratory standpoint, Claimant can do his usual coal mine employment (EX 5).

Initially, I accord less weight to the opinions of Drs. Williams, Lane, Wright, Jarboe, and Dineen since they found no coal worker's pneumoconiosis on chest x-ray, contrary to the findings established in this case. I find the opinions of Drs. Anderson, Broudy, Baker, Sundaram and Potter that Claimant has pneumoconiosis to be well supported by the probative positive chest x-ray findings. I accord less weight to the review report of Dr. Fino since he also credits the negative readings of record. I note that Dr. Westerfield reported positive findings on his own chest x-ray reading, but then in later reports stated there was no evidence of pneumoconiosis relying on x-ray reports from hospitalizations which were not read for the presence or absence of pneumoconiosis. Under these circumstances, I find Dr. Westerfield's reports reach contradictory conclusions and I find the most recent finding of no pneumoconiosis less persuasive.

I have also reviewed in detail the reports of Drs. Sundaram and Potter, the Claimant's two treating physicians. Dr. Sundaram examined Claimant repeatedly and treated him during numerous hospitalizations from 1992 through 2002. His reports note specific findings on pulmonary testing, examination as well as chest x-ray. Under the circumstances of this case, I find his reports as treating physician is entitled to additional weight as the treating physician since his report is well documented and well reasoned. *Peabody Coal Co. v. Odom*, 342 F.3d 486 (6th Cir. 2003). Similarly, Dr. Potter's report on his treatment of Claimant from 2003 and 2004 is well documented and well reasoned. Dr. Potter notes particular findings on pulmonary testing as well as the physical examination findings and coal worker's pneumoconiosis which are the basis for his finding as treating physician that Claimant has coal worker's pneumoconiosis. Thus, I also accord additional weight to Dr. Potter's July, 2004 and August, 2004 reports. Based on the more persuasive reports of Drs. Sundaram and Potter as supported by the positive chest x-ray reports and the examination reports of Dr. Anderson, Broudy, and Baker, I find the medical opinion evidence of record is sufficient to establish the presence of pneumoconiosis under the provisions of Section 718.202(a)(4).

In summary, I find the evidence is sufficient to establish the presence of pneumoconiosis under the provisions of Section 718.202(a) by the chest x-ray reports under subsection (a)(1) and by the medical opinion reports under subsection (a)(4). Therefore, I find no mistake in fact in Judge Malamphy's finding that pneumoconiosis was established in the award of benefits of May 2, 1997 as affirmed by the Board on May 15, 1998 on the issue of the presence of pneumoconiosis.

Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). The parties agreed Claimant worked thirteen years in coal mine employment. Since Claimant had more than ten years of coal mine employment, he receives the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. There is no

physician's opinion which concludes his pneumoconiosis is due to any other cause. Therefore, I find Claimant has established his coal worker's pneumoconiosis arose out of his coal mine employment. Thus, I find no mistake in fact on this issue in either the award of benefits issued by Judge Malamphy on May 2, 1997, or as affirmed by the Board on May 15, 1998.

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. 20 CFR § 718.204(b)(1). If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis and 4) a reasoned medical opinion concluding total disability.

Pulmonary Function Studies

Pulmonary function study results were submitted for evaluation on the issue of total disability under Section 718.204(b)(2)(i). The pulmonary function study results are summarized in a table included in Judge Malamphy's initial determination of August 12, 1993 (DX 37) and that description is incorporated by reference herein. In addition, the record includes the newly submitted pulmonary function study listed below:

EX. NO.	PHYSICIAN	DATE	AGE	FEV_1	FVC	FEV_1 FVC	MVV
CX 10	Potter	01-06-03	64	1.261	2.128	59%	---
				1.126	2.174	52%	---

Claimant's values on the pulmonary function studies submitted prior to the request for modification were all non-qualifying. The regulations require that a miner of Claimant's average height of 68 inches and age of 64 demonstrate an FEV-1 of 1.84 or less and an FVC of 2.36 or an FEV-1/FVC ratio of 55% or less to qualify under the regulatory standards. Therefore, Claimant's values on this most recent pulmonary function study qualify on the FEV-1 portion of the test, but not on the FVC portion of the test and on the "after bronchodilator" FEV-1/FVC ratio portion of the test. I note, however, Claimant's effort was listed as fair. Under these circumstances, I accord less weight to the results of this newest pulmonary function study. I find no mistake in fact, therefore, in the determination that the weight of the pulmonary function study evidence of record is not sufficient to establish total disability under the provisions of subsection 718.204(b)(2)(i).

Arterial Blood Gas Studies

The record includes results from ten blood gas studies taken from September, 1987 through February, 1993, as set forth in a table in the decision and order of August 12, 1993 (DX 37). Judge Malamphy accorded less weight to the February, 1993 values which several physicians stated reflected the effects of the acute condition of pneumonia for which Claimant was hospitalized and were not reliable indicators of his pulmonary capacity based on the presence of coal worker's pneumoconiosis. That finding was affirmed by the Board. There is no new evidence to demonstrate any mistake in fact in that findings. I note the initial blood gas study at rest in September 1987 was qualifying, however, I find those values outweighed by the non-qualifying values on the eight tests taken at rest after that test. I note, however, that the only exercise study of record is qualifying. Several physicians stated this qualifying test would indicate the miner would be unable to perform heavy manual labor such as coal mine employment. Based on the analysis of those results by the physicians, I find the single qualifying exercise study results outweighs the contrary non-qualifying results at rest and is sufficient to establish total disability under the provisions of subsection 718.204(b)(2)(ii).

Cor Pulmonale

A claimant may also establish total disability by providing medical evidence of cor pulmonale with right-sided congestive heart failure pursuant to Section 718.204(b)(2)(iii). As no medical evidence of cor pulmonale was admitted into the record, I find the Claimant failed to establish total disability with medical evidence of cor pulmonale.

Medical Opinions

The remaining means of establishing a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion which concludes total disability is present, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment". 20 C.F.R. §718.204(b)(2)(iv).

Dr. Fino, in his review reports, continues to conclude Claimant retains the respiratory capacity to perform his usual coal mine employment, since the objective test results are all normal. These tests, however, predate Claimant's series of hospitalizations for serious and recurring pulmonary problems, including pneumonias and respiratory distress. As discussed below, all the other physicians agreed Claimant has serious and limiting pulmonary problems. Under these circumstances, I accord very little weight to Dr. Fino's conclusions regarding Claimant's pulmonary capacity.

Similarly, several of the physicians reports which predate the request for modification also conclude Claimant is not disabled by his pulmonary or respiratory condition. These reports are all outweighed by the more recent reports which note Claimant's extensive hospitalizations and treatment for serious pulmonary problems. Therefore, I accord little weight to the opinions

of Drs. Anderson, Myers, Lane, Broudy, Wright, Jarboe, Baker and Dineen on the issue of total disability since their reports all predate the hospitalizations noted below.

Dr. Sundaram and Potter, Claimant's treating physicians, both conclude his serious and extensive pulmonary problems prevent him from performing his usual coal mine employment. These conclusions are well supported by the extensive hospital reports submitted into the record. In addition, Dr. Potter notes the results of oximetry and vital capacity as supportive of his finding Claimant is totally disabled due to his pulmonary condition. Dr. Westerfield acknowledges Claimant's pulmonary problems but attributes them to other conditions than coal worker's pneumoconiosis. However, since he does not contradict the finding that Claimant's pulmonary condition is disabling, I find his report supportive of the reports of the treating physicians that Claimant is totally disabled by his respiratory or pulmonary condition. Accordingly, I find the better supported and better reasoned reports of Drs. Sundaram, Potter and Westerfield sufficient to establish total disability under the provisions of subsection 718.204(b)(2)(iv).

The regulations also require that Claimant must establish that his total disability is due to pneumoconiosis as required by subsection 718.204(c). The Sixth Circuit requires that total disability be "due at least in part" to pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1989). In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), the Sixth Circuit stated the following: The claimant bears the burden of proving total disability due to pneumoconiosis and . . . this causal link must be more then *de minimus*. . . .To satisfy the 'due to' requirement of the BLBA and its implementing regulations, a claimant must demonstrate by a preponderance of the evidence that pneumoconiosis is 'more than merely a speculative cause of his disability,' but instead 'is a contributing cause of some discernible consequence to his totally disabling respiratory impairment.' . . . To the extent that the claimant relies on a physician's opinion to make this showing, such statements cannot be vague or conclusory, but instead must reflect reasoned medical judgment.

Initially, I accord less weight to the opinions of physicians who found Claimant does not have coal worker's pneumoconiosis since that finding is contrary to findings established in this case. Therefore, I accord less weight to the opinions of Drs. Williams, Lane, Wright, Jarboe, Dineen, and Fino who all concluded Claimant does not have pneumoconiosis. I also accord less weight to the review report of Dr. Westerfield since he initially concluded pneumoconiosis was present, but found pneumoconiosis was not present in his later reports. On consideration of the remaining medical reports, I find the conclusions of Drs. Anderson, Myers and Broudy less persuasive since their reports are earlier in time and they did not consider the more recent medical reports, including the numerous hospital reports. I find the reports of the treating physicians most persuasive on the issue of the cause of Claimant's pulmonary disability. These physicians consistently note Claimant's multiple pulmonary problems, but they also consistently note the presence of pneumoconiosis as one contributing factor in Claimant's pulmonary disability. Dr. Sundaram explained that Claimant's pneumoconiosis weakened Claimant's lungs and made him more susceptible to the series of infections and pneumonias documented in the hospital reports. Dr. Potter noted specific findings on pulmonary testing which supported his conclusion that Claimant is totally disabled due to pneumoconiosis including the results on oximetry and the low vital capacity values. Therefore, on consideration of all of the medical reports, I find the opinions of Drs. Sundaram and Potter most persuasive on the issue of the cause of Claimant's totally

disabling pulmonary condition. I find, therefore, the evidence is sufficient to establish that Claimant is totally disabled, at least in part, due to pneumoconiosis.

I have considered all the evidence of record and I find that the persuasive qualifying blood gas study and the weight of the medical opinion reports of record outweigh the "contrary probative evidence" specifically the non-qualifying at rest blood gas study tests and the non-qualifying pulmonary function study tests taken before Claimant's pulmonary condition deteriorated as demonstrated by the extensive hospital reports and reports by his treating physicians. Therefore, I find the weight of the evidence considered together is sufficient to establish total respiratory disability. *Troup v. Reading Anthracite Coal Co.*, 22 B.L.R. 1-11 (1999)(en banc).

Furthermore, since I find Claimant has established total disability due to pneumoconiosis as required by Section 718.204, I find no mistake in fact in the prior determination by Judge Malamphy as affirmed by the Board that Claimant had established total disability due to pneumoconiosis.

Since I find no mistake in fact in the prior determination that Claimant has pneumoconiosis which arose from coal mine employment and that Claimant is totally disabled due to pneumoconiosis, I find no basis for granting Employer's request for modification of the award of benefits.

ORDER

It is ordered that Employer's motion for modification shall be denied. The award of benefits entered on May 2, 1997 as affirmed by the Benefits Review Board on May 15, 1998 shall remain. Therefore, it is **ORDERED** that Johnson Coal Company, Inc. shall pay to claimant, **ELLIOTT ROWE, JR**. all benefits to which he is entitled, as augmented by his dependent wife, **INES FAYE ROWE**, commencing February, 1993.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458

and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).